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Issue date: 14Sep2001

CASE NO.: 1995-BLA-2257

BRB No.: 99-0425 BLA

IN THE MATTER OF:

BEULAH BOWERS
(Widow of James P. Bowers)
Claimant

v.

Eastern Associated Coal Co.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR
Party-in-Interest

DECISION AND ORDER ON SECOND REMAND - DENYING BENEFITS

The Employer appealed the Decision and Order after Remand of Administrative Law Judge Frederick D. Neusner[1] awarding benefits on this survivor's claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901, **et seq.** (the Act).

In their Decision and Order issued February 6, 1998, the Benefits Review Board affirmed the Judge's findings pursuant to 20 C.F.R. § 718.202(a)(1) and (3) but vacated the judge's findings pursuant to 20 C.F.R. §§ 718.202(a)(2), (4) and

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[1]Due to the unavailability of Judge Neusner, this case was assigned to Administrative Law Judge Clement J. Kichuk for consideration of the issues remanded by the Benefits Review Board and for entering a decision on the record.

718.205(c) and remanded the case for the administrative law judge to reconsider the medical opinion evidence thereunder.

On remand, the administrative law judge concluded that the evidence of record was sufficient to establish the existence of pneumoconiosis and that the miner's death was due to pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4) and 718.205(c). Judge's Decision and Order October 27, 1998.

In their latest Decision and Order issued August 29, 2000 the Benefits Review Board agreed with employer's contention that the administrative law judge erred in finding the existence of pneumoconiosis established pursuant to Section 718.202(a)(4), asserting that the judge failed to weigh all the relevant evidence of record or adequately explain his weighing of the evidence. Specifically, employer contended the judge failed to consider the opinions of Drs. Rasmussen, Fino and Tuteur and offered no rationale for not accepting or rejecting these opinions in his analysis and further erred in failing to weigh all the evidence pursuant to 20 C.F.R. § 718.202(a) in determining if claimant established the existence of pneumoconiosis. The Board also ruled the judge must specifically address the biopsy evidence and determine its credibility pursuant to 20 C.F.R. § 718.202(a)(2).

With respect to Section 718.205(c), the Board noted in relying upon Dr. Salon's opinion that pneumoconiosis contributed to the miner's death by aggravating his overall condition, the administrative law judge failed to specifically determine if the opinion of Dr. Salon was reasoned and documented or to specifically discuss and consider the opinions of Drs. Fino, Tuteur and Rasmussen or the findings of the West Virginia State Pneumoconiosis Board as they relate to claimant's burden of proof to establish that the miner's death was due to pneumoconiosis. The Board vacated the judge's findings under Section 718.205 and remanded this case to the judge to specifically discuss all the relevant evidence of record and to set forth the basis for his credibility determinations.

ISSUES

The Board remanded the following issues for reconsideration:

1. Is the evidence sufficient to establish the existence of pneumoconiosis by biopsy pursuant to Section

718.202(a)(2).

2. Is the evidence sufficient to establish the existence of legal pneumoconiosis by medical opinion pursuant to Section 718.202 (a)(4).

3. Is the evidence sufficient to establish that the miner's death was caused in part or hastened by pneumoconiosis pursuant to Section 718.205(c). **See Shuff v. Cedar Coal Co.,** 967 F 2d 977 (4th Cir. 1992) cert. denied, 113 S.Ct. 969 (1993).

4. Is the claimant entitled to survivor's benefits under the Act.

APPLICABLE LAW AND REGULATIONS

The miner, James P. Bowers never filed a claim for benefits under the federal black lung Act. The miner died on July 10, 1990. Claimant, the miner's widow filed her survivor's claim on April 22, 1994. The regulations applicable to her claim are set forth in Part 718. The Department of Labor has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001 and are found at 20 C.F.R. Parts 718, 722, 725 and 726. All citations to the regulations in this decision refer to the old regulations unless otherwise noted.

Pursuant to a lawsuit challenging revisions to forty-seven of the regulations implementing the Act, the United States District Court for the District of Columbia granted limited injunctive relief and stayed for duration of the lawsuit, all claims pending before the Office of Administrative Law Judges under the Act, except those in which the administrative law judge, after briefing by the parties to the claim, determines that the regulations at issue in the lawsuit will not affect the outcome of the case. **National Mining Ass'n v. Chao,** No. 1:00 CVF 03086 (DDC, Feb. 9, 2001)(Order granting preliminary injunction).

In the present case, this Court established a briefing schedule by Order issued on February 26, 2001 to which claimant, employer and the Director responded stating, in effect, that the amendments to Part 718 have no impact upon the outcome of this case. Meanwhile, the District Court Judge lifted the temporary

injunction and upheld the new Black Lung rules by decision issued August 9, 2001. (**National Mining Association v. Chao,** D.D.C. No. 00-3086, August 9, 2001).

In order to establish entitlement to benefits in a survivor's claim filed after January 1, 1982, claimant must establish that the miner's death was due to pneumoconiosis. See 20 C.F.R. §§ 718.201, 718.202, 718.203, 718.205(c); **Trumbo v. Reading Anthracite Co.,** 17 BLR 1-85 (1993); **Neeley v. Director, OWCP,** 11 BLR 1-85 (1988); **Boyd v. Director, OWCP,** 11 BLR 1-39 (1988). Under Section 718.205(c), death will be considered to be due to pneumoconiosis if pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. The United States Court of Appeals for the Fourth Circuit, wherein jurisdiction of this case lies, **Shupe v. Director, OWCP,**12 BLR 1-200 (1989)(en banc), held in **Shuff** that pneumoconiosis will be found to be a substantially contributing cause or factor in the miner's death where it is found to have actually hastened death.

I

EXISTENCE OF PNEUMOCONIOSIS

-A-

Proof - Pursuant to Section 718.202(a)(2)

Section 718.202(a)(2) provides a finding of the existence of pneumoconiosis may be made by biopsy:

> (2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding in an autopsy or biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis.

The biopsy evidence in this record is as follows: Dr. Wills performed a needle biopsy on June 5, 1986 and Dr. Ahmed evaluated the material extracted. (DX 10 at 23-24). Dr. Klingensmith performed a right upper and middle lobectomy on July 1, 1986 and Dr. Ahmed evaluated the lung tissue sampled. (Employer's Exhibit 5). A fiber optic bronchoscopy was performed by Dr. Cooper on July 5, 1986. **Id.** Only Dr. Ahmed's July 3, 1986 report of the July 1, 1986 lobectomy includes a

diagnosis of pneumoconiosis.

Dr. Ahmed diagnosed, inter alia, “Non Neoplastic Pathology including Simple Anthracopneumoconiosis (4).” He states “the pulmonary parenchyma along the pleural surface is generally smooth although anthracopneumoconiotic in appearance.” Nowhere in his report does Dr. Ahmed explain the specific characteristics of his use of the term “anthracopneumoconiotic” as he fails to discuss or explain its morphology. Dr. Tuteur addresses such omission as discussed infra. Dr. Ahmed stated the following observations in his microscopic analyses:

> Elsewhere additional observations in the non-neoplastic portions [of the lungs] include pleural fibrosis, emphysema, chronic inflammation, fibrosis, anthracopneumoconiosis etc. along with the inflammatory foci featuring lymphoid follicle formation.
>
> *** *** ***
>
> ....The nodes also show anthracopneumoconiosis of simple variety, fibrosis etc. with one area having some features of a healed granuloma such as that usually seen in healed fungus infection.
>
> *** *** ***
>
> With respect to the afore mentioned anthracopneumoconiosis, it is to be observed that all of the findings (including emphysema) do amount to a stage of chronic respiratory impairment. However there is no clinical occupation related history available. (EX 5).

While Dr. Ahmed indicated he finds the presence of a tumor “imperceptibly intermingling with pneumoconiotic background” he describes the tumor morphology but does not discuss the form and structure of the organism he identifies to be anthracopneumoconiosis. Since this identification is a medical determination, this court must look to an opinion of a qualified physician. I find Dr. Tuteur provides the answer in his February 5, 1996 report. (EX 6):

In relevant part Dr. Tuteur stated the following opinion in his evaluation of Dr. Ahmed’s biopsy report:

....Examination of lung tissue at the time of thoracotomy demonstrated not only the poorly differentiated adenocarcinoma, but “in the nonneoplastic portions”... “pleural fibrosis, emphysema, chronic inflammation, fibrosis, anthracopneumoconiosis, etc., along with the inflammatory foci featuring lymphoid follicle formation.” Lymph nodes shows “anthracopneumoconiosis of simple variety, fibrosis, etc., with one area having some features of a healed granuloma such as that usually seen in healed fungus infection.” No detailed description of the morphology is provided. No documentation of assessment of the presence of morphologic abnormalities fulfilling criteria for Coal Worker’s Pneumoconiosis is provided. Specifically, there is no comment with respect to any relationship of the deposition of anthracotic pigment to fibrosis or the presence of coal dust macules, nodules (other than the malignant process), or focal emphysema. The comment: “Lymph nodes also show anthracopneumoconiosis ... “is quite disconcerting insomuch as pneumoconiosis is a pulmonary (lung), not lymph node process.

*** *** ***

...Though the pathologist appends a diagnosis of “anthracopneumoconiosis” to pulmonary parenchyma distant from the malignant process, review of the surgical pathology report does not document fulfillment of criteria for the diagnosis of coal workers’ pneumoconiosis. Furthermore, review of the images of the CT scan of May, 1990, identifies only the malignant process and no diffuse interstitial abnormality consistent with coal workers’ pneumoconiosis...
....It is further with reasonable medical certainty that this dataset does not provide convincing information to allow for the diagnosis of clinically significant, physiologically-significant, or radiographically-significant coal workers’ pneumoconiosis.

This Court finds Dr. Ahmed’s diagnosis of “non-neoplastic pathology including simple anthracopneumoconiosis” is not well reasoned and fails to establish the existence of pneumoconiosis by surgical pathology method. Although this physician, a

pathologist, reported seeing evidence demonstrated existence of "anthracopneumoconiosis", he failed to disclose the distinguishing attributes he observed to be present which demonstrated this particular type of pneumoconiosis was indeed thereby portrayed. I find it significant that Dr. Tuteur, a highly qualified pulmonologist refused to accept Dr. Ahmed's diagnosis of Coal Worker's Pneumoconiosis based upon the pathologist's narrative. Dr. Tuteur specifically pointed to Dr. Ahmed's failure to provide a detailed description of the morphology and to provide documentation of assessment of the presence of morphologic abnormalities fulfilling criteria for coal worker's pneumoconiosis. Specifically, there was no comment with respect to any relationship of the deposition of anthracotic pigment to fibrosis, or the presence of coal dust macules, nodules (other than the malignant process), or focal emphysema.

I give little weight to Dr. Ahmed's opinion that there was sufficient evidence to establish the presence and diagnosis of pneumoconiosis by biopsy. I give great weight to Dr. Tuteur's evaluation of Dr. Ahmed's comments. This Court finds and concludes that the evidence is not sufficient to establish the existence of pneumoconiosis by biopsy pursuant to Section 718.202(a)(2).

-B-

PROOF - Pursuant to Section 718.202(a)(4)

Reasoned Medical Opinion

I now turn to the question of whether the medical opinion evidence supports a finding that Mr. Bowers suffered from any form of pneumoconiosis as defined in the regulations. Section 718.202(a)(4) provides a determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray finds that the miner suffers or suffered from pneumoconiosis as defined in Section 718.201. Any such finding shall be based on objective medical evidence .... Such a finding shall be supported by a reasoned medical opinion.

Dr. Salon, Rasmussen and Klingensmith reported in their judgment the miner suffered from some form of coal worker's

pneumoconiosis.

As noted, supra, Dr. Ahmed based his diagnosis of pneumoconiosis upon observation and examination of the lung specimens but noted there was no clinical occupation related history available. Thus Dr. Ahmed made no statement specifically relating the pneumoconiosis to coal mine employment.

Dr. Salon treated the miner since 1977 "because of chronic lung trouble." (EX 5) In his Discharge Summary dated June 30, 1986 the doctor noted the miner had a "history of chronic obstructive pulmonary disease with coal workers' pneumoconiosis" and included the quoted comment in the Final Diagnosis together with "right apical mass right lung secondary to squamous cell carcinoma poorly differentiated." **Id.** Dr. Salon also treated the miner during his final hospitalization which terminated in his demise. In his Discharge Summary dated August 15, 1990, Dr. Salon diagnosed (1) Recurrent carcinoma of the right lung with metastases, complicated with heart failure and hypertension; (2) chronic obstructive pulmonary disease with severe hypoxemia, and (3) Atherosclerotic cardiovascular disease. (DX 10). He also indicated that the miner's chest x-ray showed no evidence of active cardiopulmonary disease and that another chest x-ray showed mild pulmonary vascular congestion. **Id.** I find Dr. Salon's opinion falls short from qualifying as a reasoned medical opinion. The doctor fails to explain the basis for his diagnosing coal worker's pneumoconiosis nor does he provide documentation supporting the diagnosis of pneumoconiosis. The regulation at 718.202(a)(4) demands that the finding of pneumoconiosis, notwithstanding a negative x-ray, shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical examination and medical and work histories. This court notes the record contains no pulmonary function test reports and no blood gas studies and the x-ray evidence has been adjudged insufficient to establish the existence of pneumoconiosis. This Court also notes that Dr. Salon wrote the Death Certificate, (DX 9), dated July 10, 1990 but did not include pneumoconiosis as a contributing cause of death. Nevertheless, in a letter dated June 1, 1993, Dr. Salon included the statement "[the miner] had multiple medical problems, one of them being coal workers' pneumoconiosis..." (DX 11). Here again, Dr. Salon gives no explanation in this two paragraph letter, how he arrived at the conclusion that coal workers' pneumoconiosis was one of the

"multiple medical problems" affecting the miner's overall health condition. I find Dr. Salon's opinion of the existence of pneumoconiosis is conclusory at best and is not sufficient to establish clinical pneumoconiosis or legal pneumoconiosis pursuant to Section 718.202(a)(4). Dr. Salon has no expertise in the field of pulmonary diseases. His opinion is refuted by the contrary probative evidence and by physicians possessing superior qualifications as discussed infra. As the miner's treating physician since 1977, Dr. Salon may well have known the miner's work and smoking histories and that the miner was awarded benefits for total disability due to pneumoconiosis by the State Pneumoconiosis Board in 1976. However, Dr. Salon fails to provide the record with any explanation to inform this Court the identity of the evidence which he found was present to establish the existence of clinical pneumoconiosis or legal pneumoconiosis. Accordingly, I find Dr. Salon's opinion of the existence of pneumoconiosis is unexplained, ambiguous, lacks documentation and is not supported by substantial evidence.

Dr. Klingensmith examined the miner on June 16, 1986 "in order to determine his candidacy for exploration." He performed the Right Upper and Middle Lobectomy on July 1, 1986. The doctor noted the miner's smoking history and 39 years of coal mine employment. (DX 10 at 18). In his report of June 16, 1986 the doctor stated:

> Review of x-rays show a golfball size lesion in the right upper lobe.
>
> Impression: Undifferentiated carcinoma, right upper lobe, coal worker's pneumoconiosis

Dr. Klingensmith does not inform or explain why he included "coal worker's pneumoconiosis" in reporting his impression. This single statement, without more, does not constitute a reasoned medical opinion sufficient to establish the existence of clinical or legal pneumoconiosis pursuant to Section 718.202(a)(4) and I so find. Accordingly I give no weight to Dr. Klingensmith's opinion.

Drs. Tuteur, Rasmussen and Fino reviewed all the medical evidence listed in their respective reports provided in 1996. These three physicians did not examine the miner who died on July 10, 1990. Dr. Rasmussen, who is board certified in internal medicine, made a diagnosis of coal worker's pneumoconiosis. Drs. Tuteur and Fino are board certified in

internal medicine and in pulmonary diseases and each one is a B reader. Drs. Tuteur and Fino found the evidence did not establish the existence of clinical or legal pneumoconiosis.

[(Dr. Rasmussen's Report (July 16, 1996)). (CX 5)]

Dr. Rasmussen reviewed the medical evidence listed in his report, which included the reports from the State Occupational Pneumoconiosis Board granting total disability due to pneumoconiosis benefits in 1976 and refusing to grant survivor's benefits to claimant. The review also included hospital records, x-rays, Death Certificate and the reports by Drs. Tuteur and Ahmed. Dr. Rasmussen reached the conclusion that Mr. Bowers suffered from chronic obstructive pulmonary disease including coal workers' pneumoconiosis which resulted from his 39 years of coal dust exposure and cigarette smoking and opined that both primarily caused his death. Dr. Rasmussen noted that chest x-ray "may be quite unreliable in determining or excluding the presence of coal workers' pneumoconiosis. Responding to Dr. Tuteur's interpretation of x-rays showing no evidence of pneumoconiosis, Dr. Rasmussen pointed to the x-ray findings "which in fact were reported positive or consistent with pneumoconiosis" ..."by Dr. Bassali" ... "and definitely positive by Dr. Daniels," ... "cannot be used to exclude the presence of significant pneumoconiosis..."

Dr. Rasmussen directs criticism against Dr. Tuteur who "asserted that coal mine dust produces a restrictive lung disease in effected (sic) miners. This is not true except perhaps in the case of very advanced, complicated pneumoconiosis." Dr. Rasmussen then continues to explain stating "There is, however, a large body of evidence indicating that obstructive pulmonary disease may well be a consequence of coal mine dust exposure." The doctor goes on to identify the various medical studies which he considers justify his challenge against Tuteur's alleged comments. Dr. Rasmussen also points to a series of medical articles which constitute "....growing evidence that coal mine dust exposure is capable of producing centrilobuler emphysema." Dr. Rasmussen also refers to medical reports which, in his opinion, demonstrate "mortality statistics indicate that coal miners die at a much higher rate from chronic bronchitis and emphysema than all other occupational groups. Drs. Tuteur and Fino express opinions contrary to Dr. Rasmussen as discussed infra by this Court.

Dr. Rasmussen sums up his conclusion and opinions stating

the following:

> There are at least 3 and perhaps 4 causes of this patient*s ultimately fatal chronic lung disease. These include: 1) the patient*s 39 years of exposure to coal mine dust with its resultant occupational pneumoconiosis; 2) cigarette smoking which was significant; 3) right upper and middle lobectomies performed in 1986; and 4) he may have had some contribution from x-ray therapy.
>
> This patient was found to have totally disabling lung disease in 1976. This disability was attributed to his occupational pneumoconiosis. The subsequent development of carcinoma of the lung was not the consequence of his occupational dust exposure, but primarily from his cigarette smoking. This patient*s underlying chronic lung disease, which was the consequence of his smoking and occupational pneumoconiosis, rendered him less capable of long-term survival from his right upper and middle lobectomies, and possibly subsequent x-ray therapy.
>
> It is my opinion to a reasonable degree of medical certainty that Mr. James P. Bowers suffered from a chronic disabling dust disease of the lung including coal workers* pneumoconiosis which were the consequences of his 39 years of coal mine dust exposure and his cigarette smoking. His chronic disabling lung disease was the primary cause of the patient*s demise. Thus, the patient*s coal mine dust exposure was a significant and major contributing factor to this patient*s death.
>
> Dr. Tuteur Report (February 5, 1996). (EX 6).

Dr. Tuteur's review included hospital records of the miner's treatment in June 1986, July 1990, CT Scan dated May 18, 1990, numerous chest radiographic reports performed on eight different dates and the pathology report by Dr. Ahmed as well as Mr. Bowers' work, medical and smoking histories. As discussed supra, Dr. Tuteur at great length evaluated Dr. Ahmed's report of findings. He explained in reasoned interpretation his non-acceptance of Ahmed's diagnosis of "non-neoplastic pathology including simple anthracopneumoconiosis."

In discrediting Dr. Ahmed's diagnosis of coal workers' pneumoconiosis, Dr. Tuteur directed attention to "the lung parenchyma as seen on CT scanning that is free of a diffuse interstitial pulmonary process speaks strongly against the diagnosis of simple coal workers' pneumoconiosis." Dr. Tuteur took notice of the importance to review pulmonary function studies prior to the 1986 surgery "and for a qualified pulmonary pathologist to review the resected lung tissue for the presence or absence of criteria fulfilling the diagnosis of pathologically-significant coal workers' pneumoconiosis." Dr. Tuteur went on to state

> ....For the former, a restrictive ventilatory defect (reduced total lung capacity) would be consistent with physiologic abnormalities caused by coal workers' pneumoconiosis and for the latter the presence of dust-related fibrosis, coal dust macules, macro- and micronodules and focal emphysema would fulfill criteria for the diagnosis of pathologically-significant coal workers' pneumoconiosis. Short of such findings, based on the currently available data, it is with reasonable medical certainty that Mr. James P. Bowers did not have coal workers' pneumoconiosis or any other coal-mine-dust-related disease or condition that was of clinical or physiologic significance or that contributed to hastened or caused his death.

Dr. Tuteur - Supplemental Report (September 30, 1996) (EX 8).

Dr. Tuteur's report included review of 17 additional chest radiographic reports, hospital records of treatment in June 1986, Death Certificate, Dr. Salon's letter dated June 1, 1993, CT scan performed May 18, 1990 and Dr. Rasmussen's letter in the form of an independent medical review dated July 16, 1996. Upon reviewing the totality of all available medical data, both those data reviewed initially, as well as the newly available data, Dr. Tuteur stated the combined data continue to support the conclusions reached as expressed in his initial independent review. Dr. Tuteur explained

> Specifically with reasonable medical certainty, there is no convincing evidence to indicate the presence of clinically-significant physiologically-significant, or even radiographically-significant coal workers' pneumoconiosis. Even if Mr. Bowers did have

> pathologically-indentified coal workers' pneumoconiosis, there is no indication to support the concept that it was of sufficient profusion and severity to cause clinical symptoms, physical examination abnormalities, or physiologic impairment. Clearly, it would have been of insufficient profusion and severity to contribute to, hasten, or cause his death. (EX 8 at 2).

Dr. Tuteur engages in a very detailed analysis of Dr. Rasmussen's criticism of the conclusions reached above by Dr. Tuteur. Dr. Tuteur explains how the medical studies he cited justify his discrediting Dr. Ahmed's diagnosis of coal workers' pneumoconiosis. Responding to Dr. Rasmussen's comments about the CT scan. Dr. Tuteur explains how "in this case, the description of pathologic findings is insufficiently detailed to confirm such a diagnosis. Even if such a diagnosis were made and made appropriately, it would not imply that it was of sufficient severity or profusion to cause physiologic impairment and, thus, contribute to the adverse clinical course experienced by Mr. Bowers or render him disabled from working in the coal mine industry." **Id.** at 3.

Dr. Tuteur agreed with the concept, as did Dr. Rasmussen, that persons with "normal chest x-rays" may have coal workers' pneumoconiosis. However, Dr. Tuteur reminded a correlation exists in combining the modalities. He asserted that "Thus, combining the modalities of chest radiograph, CT Scan, and histology, when the radiographs and CT scans are interpreted as negative and the description of the pathology fails to fulfill the criteria for coal workers' pneumoconiosis, the robustness of the conclusion indicating the absence of coal workers' pneumoconiosis improves." **Id.** at 3.

Dr. Tuteur responded at length to Dr. Rasmussen's incorrect comments on the issue of whether the inhalation of coal mine dust results in a physiologically-significant obstructive or restrictive ventilatory defect. Dr. Tuteur discusses in detail the series of articles cited by Dr. Rasmussen purporting to demonstrate "a large body of evidence indicating that obstructive pulmonary disease may well be a consequence of coal mine dust exposures." Dr. Tuteur asserts "In general these studies are poorly designed, uninterpretable, and fail to support the concept that coal mine dust" may well be "inducing obstructive pulmonary disease. Dr. Tuteur proceeds to explain

the specific flaws in each of the studies cited by Dr. Rasmussen. Dr. Tuteur explains his own understanding of the factors necessary to be present in order to produce the existence of an obstructive or restrictive ventilatory defect resulting from the inhalation of coal mine dust as distinguished from a ventilatory defect resulting from cigarette smoking.

Dr. Tuteur concluded his report stating

> In summary, Mr. James P. Bowers died with and because of carcinoma of the lung due to the chronic inhalation of cigarette smoke. Furthermore, based on the totality of all available medical data, he does not have clinically-significant,physiologically-significant, radiographically-significant, or indication of pathologically-significant coal workers* pneumoconiosis.
>
> Dr. Rasmussen*s comments indicating that the chronic inhalation of coal mine dust with or without the development of coal workers* pneumoconiosis may result in physiologically-significant airways obstruction, the development of emphysema, and the augmentation of mortality rates, are based on literature characterized by flawed study design, invalid data collection, and inappropriate conclusions.

Dr. Fino report (September 28, 1996) (EX 7)

Dr. Fino reviewed the medical evidence which included multiple chest x-ray readings, hospital admissions in 1986 and 1990, CT Scan, Death Certificate, Occupational Pneumoconiosis Board Decision May 21, 1991, Dr. Salon’s letter June 1, 1993, Dr. Tuteur’s report dated February 5, 1996 and Dr. Rasmussen’s report dated July 16, 1996.

Dr. Fino agreed with Dr. Rasmussen that this man had severe pulmonary insufficiency at the time of his terminal hospitalization. The blood oxygen was only 45. Dr. Rasmussen stated that the patient died primarily due to pulmonary insufficiency and that he had no evidence of pulmonary metastases at the time of his demise. Dr. Fino states, “However, the final diagnosis was in fact recurrent carcinoma of the lung with metastases.” Dr. Fino noted the surgical pathology from the lung biopsy, as discussed during the hospitalization from June 30, 1986 through July 18, 1986, did

not describe any changes consistent with coal mine dust-related pulmonary condition. This man clearly had significant pulmonary insufficiency at the time of the hospitalization but there is no evidence of a coal mine dust-related pulmonary condition.

Dr. Fino reviewed Dr. Rasmussen's report discussing the various references cited in his report which focused upon the various types of emphysema affecting coal miners. Dr. Fino discussed at length that emphysema has both a pathological and clinical meaning. He explained from a pathological standpoint, emphysema means dilatation or enlargement of air spaces/air sacs in the lungs. Pathological emphysema does not imply any clinical impairment, It is merely a description of what is seen when lung tissue is viewed under the microscope. Dr. Fino noted it is well established that there is a pathological form of emphysema in simple coal workers' pneumoconiosis which has been described as focal emphysema. Certainly it is well known that cigarette smoking is the leading cause of centrilobular (centriacinar) emphysema.

Dr. Fino noted the majority of chest x-rays were read as negative for pneumoconiosis. The same was true with the majority of CT scans. Dr. Fino agreed with Dr. Rasmussen that one should not exclude coal workers' pneumoconiosis on the basis of the chest x-ray alone. Dr. Fino noted there is no objective data in this case to suggest a coal mine dust-related pulmonary condition. Specifically, the lung surgery did not show changes consistent with coal mine dust-related condition. Dr. Fino noted the patient was undergoing active radiation therapy shortly before he passed away and that radiation therapy can cause significant lung disease and hypoxia. In Dr. Fino's opinion this would be the cause of the low blood oxygen level. Dr. Fino stated his conclusion

1. There is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis.

2. It is my opinion that this man did not suffer from an occupationally acquired pulmonary condition.

3. This man's death was unrelated to the inhalation of coal mine dust.

4. It is my opinion that he would have died as and when he did had he never stepped foot in the coal mines.

*** *** *** *** ***

Discussion - Medical Opinion Evidence

Dr. Rasmussen stated "It is my opinion to a reasonable degree of medical certainty that Mr. James P. Bowers suffered from a chronic disabling dust disease of the lung including coal workers' pneumoconiosis which were the consequences of his 39 years of coal mine dust exposure and his cigarette smoking..."

I find Dr. Rasmussen's opinion is not supported by sufficient probative and reliable evidence. I find his opinion is outweighed by the opinions of Drs. Tuteur and Fino which I find supported by substantial probative evidence and present greater reliability. In great measure Dr. Rasmussen based his opinion more on inference and presumption in the absence of the evidence on actual proof of the fact. His refusal to discredit the positive chest x-ray readings indicates to this Court that Dr. Rasmussen did not have the opportunity to review the vast number of negative readings by expert physicians. Dr. Rasmussen's reliance upon the 39 years of coal mine employment appears to be over emphasized as he tends to imply that the 39 years of coal mine dust exposure resulted in the miner's pneumoconiosis. Dr. Rasmussen asserted that "the standard CT scan with 10 mm. cuts is insufficient to exclude the presence of occupational pneumoconiosis." On the other hand, Dr. Fino responds stating "although a standard CT scan is not the same as a high-resolution CT scan, it is nevertheless an extremely sensitive test for detecting coal workers' pneumoconiosis."

I give greatest weight to the opinions of Drs. Tuteur and Fino, both having superior qualifications as pulmonologists, and both having reviewed the medical evidence in greater depth than Dr. Rasmussen. I find Drs. Tuteur and Fino are more persuasive as their opinions are based upon specific findings of medical evidence which exists to supports their opinion that the objective medical evidence is not sufficient to justify a diagnosis of coal workers' pneumoconiosis. Both Drs. Tuteur and Fino reviewed the x-ray evidence, reviewed and/or considered the lung biopsy evidence and also reviewed the various medical reports, CT scans and considered the miner's medical, occupational and smoking histories.

I also find the opinions of Drs. Tuteur and Fino outweigh the opinions of Drs. Klingensmith, Ahmed and Salon or discussed

supra. Thus I find the medical opinion evidence is not sufficient to establish the existence of legal pneumoconiosis pursuant to Section 718.202(a)(4). This Court finds the evidence is not sufficient to establish th existence of pneumoconiosis by biopsy under § 718.202(a)(2) or by reasoned medical opinion under § 718.202(a)(4). The Board affirmed the prior finding by Judge Neusner that the evidence did not establish the existence of pneumoconiosis by x-ray pursuant to § 718.202(a)(1) nor by presumption pursuant to § 718.202(a)(3). Accordingly, this court finds and concludes that the evidence in the record of this case is not sufficient to justify a finding of pneumoconiosis under any method set forth in Section 718.202(a)(1) through (a)(4). Accordingly the failure to establish the existence of pneumoconiosis by any method precludes the claimant from entitlement to survivor's benefits under the Act.

II

Death due to pneumoconiosis - Section 718.205(c).

Assuming arguendo that the evidence was sufficient to establish the existence of coal workers' pneumoconiosis, in order to establish entitlement to survivor's benefits, this claimant must establish that the miner's death was due to pneumoconiosis. Under Section 718.205(c), death will be considered to be due to pneumoconiosis if pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. The United States Court of Appeals for the Fourth Circuit, wherein jurisdiction of this case lies, has held that pneumoconiosis will be considered a substantially contributing cause of death when it actually hastens the miner's death. **Shuff v. Cedar Coal Co., supra.**

Drs. Salon and Rasmussen expressed opinions indicating coal workers' pneumoconiosis contributed to the miner's death.

In his letter dated June 1, 1993, Dr. Salon stated that

> Mr. James Bowers....had multiple medical problems, one of them being coal workers' pneumoconiosis. I cannot say, however, that his life would have been enhanced had he not suffered from coal workers' pneumoconiosis because of the seriousness of his other medical problems.

> Insufficient oxygen intake can cause healthy cells in the body to die and can weaken the body causing the patient to have low resistance, making him susceptible to sickness and disease. The affects (sic) of this patients' (sic) coal workers' pneumoconiosis aggravated his overall condition and I believe, was a contributing factor in his death, to what degree, I have no way of knowing. (DX 11).

Once again Dr. Salon fails to explain how the medical evidence establishes that the alleged coal workers' pneumoconiosis aggravated the miner's overall condition and contributed to his death in light of the miner's metastatic lung cancer. Nor did Dr. Salon reconcile the above quoted comments of causality with his diagnosis stated in his Discharge Summary dated August 15, 1990 where pneumoconiosis is not mentioned at all. Likewise the Death Certificate he wrote did not include pneumoconiosis as an active participant in the miner's demise. This court also notes that Dr. Fino, a pulmonologist, found that the miner's hypoxia was due to emphysema which resulted from cigarette smoking. I find Dr. Salon's opinion stating the miner's coal workers' pneumoconiosis "aggravated his overall condition" and was "a contributing factor in his death, to what degree I have no way of knowing" is equivocal and not reasoned. I find his opinion is conclusory as the doctor provides no supportive documentation. I find I can give no weight at all to Dr. Salon's opinion stating that coal workers' pneumoconiosis aggravated the miner's overall condition and that he believed pneumoconiosis was a contributing factor in the miner's death.

Dr. Rasmussen opined "to a reasonable degree of medical certainty" that Mr. James P. Bowers suffered from a chronic disabling dust disease of the lung including coal workers' pneumoconiosis and cigarette smoking. He then stated "the chronic disabling lung disease was the primary cause of the patient's demise. Dr. Rasmussen concludes by stating "Thus, the patient's coal mine dust exposure was a significant and major contributing factor to this patient's death."

This court can give little weight to Dr. Rasmussen's opinion and conclusions that the coal mine dust exposure was a significant and major contributory factor to this miner's death. The doctor's opinion and conclusion fail to provide reliable, probative and substantial evidence of sufficient quality and quantity to support a finding that the miner's death was due in part or hastened by pneumoconiosis.

Dr. Rasmussen offers no explanation as to the basis for his conclusion that the miner did suffer from coal workers' pneumoconiosis and coal dust exposure which reached severity status sufficient to become a "significant and major contributing factor" to the miner's death. While Dr. Rasmussen urges that the "chronic disabling lung disease was the primary cause of the patient's demise," there is substantial contrary probative evidence that the miner died due to carcinoma of the right lung with metastasis. Dr. Tuteur clearly explained "even if Mr. Bowers did have pathologically identified coal workers' pneumoconiosis, there is no indication to support the concept that it was of sufficient profusion and severity to cause clinical symptoms, no abnormalities or...impairment. Clearly, it would have been of insufficient profusion and severity to contribute to, hasten, or cause his death." I find Dr. Tuteur's explanation is more reliable as he based his opinion upon specific evidence which has not been contradicted.

Whereas Dr. Rasmussen noted the miner was found by the Pneumoconiosis Board in 1976 to have disabling lung disease attributed to his occupational pneumoconiosis, the court notes that the Occupational Pneumoconiosis Board expressed their opinion in 1991 that occupational pneumoconiosis was not a major contributing factor in his death. While the finding of the Pneumoconiosis Board is not binding upon this Court or on Dr. Rasmussen's analysis, it indicates disagreement with Dr. Rasmussen finding occupational pneumoconiosis was a significant and major contributing factor to the miner's death. Then again, to the extent the West Virginia Pneumoconiosis Board decided to deny survivor's benefits, it supports the conclusions of Drs. Tuteur and Fino that the miner's exposure to coal dust did not contribute to or hasten his death.

This Court gives greatest weight to the opinions of Drs. Tuteur and Fino. Both doctors have qualifications superior to Dr. Rasmussen as both are board certified pulmonologists. Both doctors explain the basis for their conclusion that the miner's death was not due at least in part by coal dust exposure and that pneumoconiosis did not hasten death. Dr. Tuteur and Dr. Fino reviewed all the medical evidence and each explained the evidence showed the cause of death was the metastatic carcinoma of the lung due to the chronic inhalation of cigarette smoke. I find Dr. Tuteur and Fino provide well reasoned opinions which they support with all the available probative evidence and documentation.

CONCLUSION

I find and conclude that the claimant has failed to present sufficient evidence to sustain by a preponderance her burden of proof to establish that Mr. James Bowers' death was due to pneumoconiosis or that pneumoconiosis was a substantially contributing cause or factor leading to his death or that death was hastened by pneumoconiosis, pursuant to Section 718.205(c). Accordingly, I find the claimant has not established entitlement to survivor's benefits.

DECISION AND ORDER

It is ordered that the claim of Beulah Bowers for survivor's benefits under the Act, is DENIED.

A
CLEMENT J. KICHUK
Administrative Law Judge

Boston, Massachusetts
CJK:dr

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this order, by filing a Notice of Appeal with the Benefits Review Board; U.S. Department of Labor; Room S-5220, FPB; 200 Constitution Avenue, N.W., Washington, DC 20210; ATTN: Clerk of the Board. A copy of this Notice of Appeal must also be served on Donald S. Shire, Esq.; Associate Solicitor for Black Lung Benefits; U.S. Department of Labor; Room N-2117, FPB; 200 Constitution Avenue, N.W.; Washington, DC 20210.